Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

NATIONAL QUALITY MEASURES CLEARINGHOUSE

General

Title

Utilization of the PHQ-9 to monitor depression symptoms for adolescents and adults: percentage of members 12 and older with a diagnosis of major depression or dysthymia who are included in an electronic clinical data system (ECDS).

Source(s)

National Committee for Quality Assurance (NCQA). HEDIS 2016: Healthcare Effectiveness Data and Information Set. Vol. 1, narrative. Washington (DC): National Committee for Quality Assurance (NCQA); 2015. various p.

National Committee for Quality Assurance (NCQA). HEDIS 2016: Healthcare Effectiveness Data and Information Set. Vol. 2, technical specifications for health plans. Washington (DC): National Committee for Quality Assurance (NCQA); 2015. various p.

Measure Domain

Primary Measure Domain

Related Health Care Delivery Measures: Use of Services

Secondary Measure Domain

Does not apply to this measure

Brief Abstract

Description

This measure is used to assess the percentage of members 12 years of age and older with a diagnosis of major depression or dysthymia who are included in an electronic clinical data system (ECDS).

See the related National Quality Measures Clearinghouse (NQMC) summary of the National Committee for Quality Assurance (NCQA) measure Utilization of the PHQ-9 to monitor depression symptoms for adolescents and adults: percentage of members 12 and older with a diagnosis of major depression or dysthymia who are covered by an electronic clinical data system (ECDS) who have either a PHQ-9 or PHQ-A score present in their record.

Rationale

Major depressive disorder (MDD) is a leading cause of disability worldwide, affecting an estimated 120 million people (Murray et al., 2012). The lifelong prevalence is estimated to range from 10 to 15 percent (Lépine & Briley, 2011). In the United States (U.S.), 15.7 percent of people report that at some point in their lifetime they were told by a health care professional that they had depression (Centers for Disease Control and Prevention [CDC], 2009).

Depression is also associated with other chronic medical conditions and increased morbidity and mortality. The mortality risk for suicide in depressed patients is more than 20-fold greater than in the general population (Bostwick & Pankratz, 2000). In terms of other chronic conditions, depression is associated with a 60 percent increased risk of type 2 diabetes (Mezuk et al., 2008) and has been identified as a risk factor for development of cardiovascular disease (Van der Kooy et al., 2007).

In adolescents, depression can also result in serious long-term morbidities such as generalized anxiety disorder and panic disorder or lead to engagement in risky behaviors such as substance use (Taylor et al., 1996; Foley, Carlton, & Howell, 1996; Friedman et al., 1996). Adolescent-onset depression increases the risk of attempted suicide by five-fold, compared with nondepressed adolescents (Garber et al., 2009). Most adolescents who commit suicide - the third leading cause of death among 15 to 24 year olds - have a previous history of depression (Williams et al., 2009).

Depression has large effects on both health care costs and lost productivity. Adolescents with depression have higher medical expenditures, including those related to general and mental health care, than adolescents without a diagnosis of depression (O'Connor et al., 2009). A recent study showed a relationship between the severity of depression symptoms and work function in working-age adults, and found that for every 1-point increase in the Patient Health Questionnaire (PHQ-9) score (a measure of depression severity), patients experienced an additional mean productivity loss of 1.65 percent. In a survey study, Birnbaum et al. (2010) found that major depressive disorder severity is significantly associated with increased treatment usage and costs, unemployment, disability and reduced work performance. When the results of the study were projected to the U.S. workforce, it was estimated that monthly depression-related worker productivity losses had human capital costs of nearly $2 billion.

Numerous studies have found that patient outcomes improve when there is collaboration between a primary care doctor, case manager and a mental health specialist to screen for depression, monitor symptoms, provide treatment and refer to specialty care as needed (Von Korff & Goldberg, 2001; Gilbody et al., 2006; Thota et al., 2012; Katon & Seelig, 2008; Unützer et al., 2002). Standardized instruments are useful in identifying meaningful change in clinical outcomes over time. Guidelines recommend that providers establish and maintain regular follow-up with patients diagnosed with depression and use a standardized tool to track symptoms (Mitchell et al., 2013; Cheung et al., 2007).

Evidence for Rationale

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Primary Health Components

Major depression; dysthymia; electronic clinical data system (ECDS); adolescents

Denominator Description

Members age 12 years and older as of January 1 of the measurement year with an active diagnosis of major depression or dysthymia (see the related "Denominator Inclusions/Exclusions" field)

Numerator Description

All members for whom a plan can receive HEDIS measure electronic clinical data system (ECDS) data (see the related "Numerator Inclusions/Exclusions" field)

Evidence Supporting the Measure

Type of Evidence Supporting the Criterion of Quality for the Measure

A clinical practice guideline or other peer-reviewed synthesis of the clinical research evidence

A formal consensus procedure, involving experts in relevant clinical, methodological, public health and organizational sciences

A systematic review of the clinical research literature (e.g., Cochrane Review)

One or more research studies published in a National Library of Medicine (NLM) indexed, peer-reviewed journal

Additional Information Supporting Need for the Measure

Unspecified

Extent of Measure Testing

All HEDIS measures undergo systematic assessment of face validity with review by measurement advisory panels, expert panels, a formal public comment process and approval by the National Committee for Quality Assurance's (NCQA's) Committee on Performance Measurement and Board of Directors. Where applicable, measures also are assessed for construct validity using the Pearson correlation test. All measures undergo formal reliability testing of the performance measure score using beta-binomial statistical analysis.

Evidence for Extent of Measure Testing

Rehm B. (Assistant Vice President, Performance Measurement, National Committee for Quality Assurance, Washington, DC). Personal communication. 2015 Mar 16. 1 p.

State of Use of the Measure

State of Use

Current routine use

Current Use

not defined yet

Application of the Measure in its Current Use

Measurement Setting

Ambulatory/Office-based Care

Behavioral Health Care

Managed Care Plans

Professionals Involved in Delivery of Health Services

not defined yet

Least Aggregated Level of Services Delivery Addressed

Single Health Care Delivery or Public Health Organizations

Statement of Acceptable Minimum Sample Size

Unspecified

Target Population Age

Age 12 years and older

Target Population Gender

Either male or female

National Strategy for Quality Improvement in Health Care

National Quality Strategy Priority

Institute of Medicine (IOM) National Health Care Quality Report Categories

IOM Care Need

Not within an IOM Care Need

IOM Domain

Not within an IOM Domain

Data Collection for the Measure

Case Finding Period

The measurement year

Denominator Sampling Frame

Enrollees or beneficiaries

Denominator (Index) Event or Characteristic

Clinical Condition

Encounter

Patient/Individual (Consumer) Characteristic

Denominator Time Window

not defined yet

Denominator Inclusions/Exclusions

Inclusions
Members age 12 years and older as of January 1 of the measurement year with an active diagnosis of major depression or dysthymia

To identify the eligible population:

> Identify all members in claims with an active diagnosis of major depression or dysthymia (Major Depression and Dysthymia Value Set) that starts before the beginning of the measurement year or during the measurement year.
> Identify all members from the previous step with an active diagnosis of depression that starts before or occurs during an outpatient encounter (Depression Encounter Value Set) during the measurement year.

Note:

> Members must have been continuously enrolled during the measurement year.
> *Allowable Gap*: No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage.

Refer to the original measure documentation for steps to identify the eligible population.

Exclusions
Exclude members with an active diagnosis from any of the following value sets, at any time during the measurement year:

> Bipolar disorder (Bipolar Disorder Value Set: Bipolar Disorder ECDS Value Set; Other Bipolar Disorder Value Set)
> Personality disorder (Personality Disorder Value Set)
> Psychotic disorder (Psychotic Disorders Value Set)
> Autism spectrum disorder (Pervasive Developmental Disorder Value Set)

Value Set Information
Measure specifications reference value sets that must be used for HEDIS reporting. A value set is the complete set of codes used to identify the service(s) or condition(s) included in the measure. Refer to the NCQA Web site to purchase HEDIS Volume 2, which includes the Value Set Directory.

Exclusions/Exceptions

not defined yet

Numerator Inclusions/Exclusions

Inclusions
All members for whom a plan can receive HEDIS measure electronic clinical data system (ECDS) data

Note:

> *ECDS*: A structured, electronic version of a patient's comprehensive medical experiences, maintained over time, that may include some or all key administrative clinical data relevant to care (e.g., demographics, progress notes, problems, medications, vital signs, past medical history, social history, immunizations, laboratory data, radiology reports). The ECDS provides automated access to comprehensive information and can create data files for quality reporting. The ECDS may also support other care-related activities directly or indirectly through various interfaces, including evidence-based decision support, quality management and outcome reporting. To qualify for this measure, ECDS data must be automated data that is accessible by the healthcare team at the point of care (e.g., electronic health records, registries and case management or disease management systems to which any provider interacting with the member has access to the clinical interface).

Value Set Information
Measure specifications reference value sets that must be used for HEDIS reporting. A value set is the

complete set of codes used to identify the service(s) or condition(s) included in the measure. Refer to the NCQA Web site to purchase HEDIS Volume 2, which includes the Value Set Directory.

Numerator Search Strategy

Fixed time period or point in time

Data Source

Administrative clinical data

Electronic health/medical record

Registry data

Type of Health State

Does not apply to this measure

Instruments Used and/or Associated with the Measure

Unspecified

Computation of the Measure

Measure Specifies Disaggregation

Does not apply to this measure

Scoring

Rate/Proportion

Interpretation of Score

Does not apply to this measure (i.e., there is no pre-defined preference for the measure score)

Allowance for Patient or Population Factors

not defined yet

Description of Allowance for Patient or Population Factors

This measure requires that separate rates be reported for commercial, Medicare, and Medicaid product lines.

Report four age stratifications and a total rate:

12 to 17 years
18 to 44 years
45 to 64 years
65+ years
Total

The total rate is the sum of the age stratifications.

Standard of Comparison

not defined yet

Identifying Information

Original Title

Utilization of the PHQ-9 to monitor depression symptoms for adolescents and adults (DMS): inclusion in ECDS rate.

Measure Collection Name

HEDIS 2016: Health Plan Collection

Measure Set Name

Measures Collected Using Electronic Clinical Data Systems

Submitter

National Committee for Quality Assurance - Health Care Accreditation Organization

Developer

National Committee for Quality Assurance - Health Care Accreditation Organization

Funding Source(s)

Unspecified

Composition of the Group that Developed the Measure

National Committee for Quality Assurance's (NCQA's) Measurement Advisory Panels (MAPs) are composed of clinical and research experts with an understanding of quality performance measurement in the particular clinical content areas.

Financial Disclosures/Other Potential Conflicts of Interest

In order to fulfill National Committee for Quality Assurance's (NCQA's) mission and vision of improving

health care quality through measurement, transparency and accountability, all participants in NCQA's expert panels are required to disclose potential conflicts of interest prior to their participation. The goal of this Conflict Policy is to ensure that decisions which impact development of NCQA's products and services are made as objectively as possible, without improper bias or influence.

Adaptation

This measure was not adapted from another source.

Date of Most Current Version in NQMC

2015 Oct

Measure Maintenance

Unspecified

Date of Next Anticipated Revision

Unspecified

Measure Status

This is the current release of the measure.

Measure Availability

Source available for purchase from the National Committee for Quality Measurement (NCQA) Web site .

For more information, contact NCQA at 1100 13th Street, NW, Suite 1000, Washington, DC 20005; Phone: 202-955-3500; Fax: 202-955-3599; Web site: www.ncqa.org .

Companion Documents

The following is available:

> National Committee for Quality Assurance (NCQA). HEDIS 2016: Healthcare Effectiveness Data and Information Set. Vol. 2, technical update. Washington (DC): National Committee for Quality Assurance (NCQA); 2015 Oct 1. 12 p.

For more information, contact the National Committee for Quality Assurance (NCQA) at 1100 13th Street, NW, Suite 1000, Washington, DC 20005; Phone: 202-955-3500; Fax: 202-955-3599; Web site: www.ncqa.org .

NQMC Status

This NQMC summary was completed by ECRI Institute on April 14, 2016.

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Source(s)

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